WORLD HEALTH ORGANIZATION | **ORGANISATION MONDIALE DE LA SANTE**

REGIONAL OFFICE FOR THE WESTERN PACIFIC
BUREAU REGIONAL DU PACIFIQUE OCCIDENTAL

REGIONAL COMMITTEE WPR/RC59/9

Fifty-ninth session 2 July 2008
Manila, Philippines
22–26 September 2008 ORIGINAL: ENGLISH

Provisional agenda item 15

PROGRESS REPORTS ON TECHNICAL PROGRAMMES

Avian and pandemic influenza and the Asia Pacific Strategy For Emerging Diseases

The Asia Pacific Strategy for Emerging Diseases (APSED) was endorsed by the Regional Committees for South-East Asia and the Western Pacific in September 2005. The Strategy is being implemented as a common framework and tool for countries to strengthen national and local capacities required for confronting emerging infectious diseases, including avian and pandemic influenza. APSED is recognized as a regional approach for countries to meet the core capacity requirements for surveillance and response under the International Health Regulations (2005).

In September 2007, the Regional Committee for the Western Pacific endorsed the conclusions and recommendations of the second meeting of the Asia Pacific Technical Advisory Group (TAG) on Emerging Infectious Diseases held in July 2007. The Regional Committee urged Member States and WHO to implement the TAG recommendations on strengthening national capacities to manage avian influenza, pandemic influenza and other emerging diseases.

Priority actions taken over the past year focused on responding rapidly to human infection of avian influenza; conducting exercises to test pandemic preparedness plans; assessing national capacity and developing national plans of action; and strengthening event-based surveillance, field epidemiology training, laboratory bio-safety, infection control, risk communication and zoonotic disease collaboration.

The Regional Committee is asked to note the progress made to implement the Asia Pacific Strategy for Emerging Diseases.

Vaccine-preventable diseases: poliomyelitis, measles and hepatitis B

The WHO Regional Committee for the Western Pacific, at its fifty-sixth session in September 2005, endorsed the twin goals of measles elimination and hepatitis B control by 2012. As such, the Western Pacific Region became the fourth WHO region to set a measles elimination goal and the first to set a goal for hepatitis B control through universal childhood immunization. It was also emphasized at the fifty-sixth session that continued efforts were needed to maintain the Region's poliomyelitis-free status given the risk of (1) poliomyelitis outbreaks following importation of wild poliovirus into countries previously poliomyelitis-free, and (2) circulating vaccine-derived poliovirus emerging in Member States where population immunity may not be optimal.

The Regional Committee's endorsement of the twin goals required a renewed focus on routine immunization services, case-based surveillance, monitoring of progress and supplemental immunization activities. However, some Member States have been struggling to reach and sustain adequate immunization coverage, to maintain sufficient funding for the Expanded Programme on Immunization, and to develop adequate surveillance and monitoring systems required to achieve these goals. The Regional Committee is asked to note this report and is urged to continue efforts to strengthen immunization delivery systems, enhance surveillance and recommend to Member States the use of WHO-recommended monitoring indicators to achieve these regional goals.

HIV/AIDS including sexually transmitted infections

The HIV epidemic continues to expand in the Western Pacific Region. New estimates indicate that 1.3 million people, including 21 000 children, were living with HIV/AIDS in the Region in 2007, with some 150 000 new HIV infections and 63 000 AIDS-related deaths.

In 2007, the *WHO Framework for Global Monitoring and Reporting on the Health Sector's Response towards Universal Access to HIV/AIDS Treatment, Prevention, Care and Support, 2007-2010* was introduced. Ten countries in the Western Pacific Region submitted data for inclusion in the second annual progress report on the global health sector response to HIV/AIDS, *Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector*, published in June 2008. The Regional Office worked intensively with countries and WHO Headquarters to collect, validate and prepare data for the global progress report. The data indicated that HIV prevention, care and treatment programmes have expanded but much remains to be done.

More resources are becoming available, particularly through the Global Fund to Fight AIDS, Tuberculosis and Malaria. One key challenge is ensuring that these resources are used strategically and effectively. Additional challenges include increasing the coverage of evidence-based programmes particularly among marginalized populations; increasing access to care, support and treatment programmes including antiretroviral therapy; generating more accurate strategic information; and building stronger health systems.

The Regional Committee is asked to note the importance of all these challenges and actions proposed in the document.

Prevention and control of tuberculosis

The Western Pacific Region continues to make good progress towards achieving the tuberculosis control goals set by the WHO Regional Committee for the Western Pacific at its fifty-first session in 2000. Aside from continuing to exceed the case-detection and treatment success rate targets, the Region has also made progress in catalysing efforts in countries and areas to improve laboratory quality and to address multidrug-resistant tuberculosis (MDR-TB) and TB-HIV co-infection.

As a result, TB prevalence and mortality have steadily declined by 23% and 15%, respectively, between 2000 and 2006. However, the Region needs to further accelerate efforts to reach the regional goal of 50% reduction in TB prevalence and mortality by 2010 from the 2000 level.

The Region needs to focus on several areas, in which progress has been insufficient, to ensure the optimal performance of TB control programmes, including: (1) scaling up MDR-TB management to meet the planned coverage of quality-assured treatment of MDR-TB patients; (2) accelerating the implementation of TB-HIV collaborative activities; (3) ensuring universal access to culture and drug susceptibility testing; (4) addressing infection control; (5) sustaining or strengthening technical assistance.

Tobacco control

Tobacco use is the second major cause of death in the world. Unless urgent action is taken it could kill an estimated one billion people during the 21st century. Eighty per cent of these deaths will occur in developing countries. One third of the world's smokers reside in the Western Pacific Region where it is estimated that two people die every minute from a tobacco-related disease. Compared with other WHO regions, the Western Pacific has the greatest number of smokers, one of the highest rates of male smoking prevalence, and the fastest increase of tobacco use uptake by women and young people.

The Region is making good progress in reversing these trends as demonstrated by Member States' commitment to implement the WHO Framework Convention on Tobacco Control (FCTC) that became international law in 2005.

The politics of tobacco control is an overarching concern. As countries begin to harmonize national laws and policies with the WHO FCTC, the demand for tobacco control efforts at global, regional and national levels will continue to increase. Strategic measures are needed to ensure sustained advocacy and action. Institutionalizing programmes, ensuring funding for tobacco control and health promotion, strengthening capacity for enforcement at local levels and mainstreaming tobacco control in noncommunicable disease plans of action are crucial.

A follow-up report is provided. The Regional Committee is urged to continue giving highest priority to rapid implementation of the Convention even beyond its minimum requirements, and endeavour to sustain and scale up tobacco control measures.

People at the Centre of Care Initiative

The global health landscape has been undergoing tremendous change. Health systems, unfortunately, have not kept pace. Global and regional trends indicate that current health systems have made remarkable progress in access and coverage, but need to be reoriented to promote and preserve health in its fullest sense. Health care quality and responsiveness to multidimensional needs, legitimate demands and expectations of patients and their families, which significantly impact health, are a continuing cause for concern globally.

Pursuant to Regional Committee resolutions WPR/RC55.R1, WPR/RC54.R2 and WPR/RC53.R6 calling on WHO to support Member States in ensuring that the formulation of health policies gives due consideration to the broader psychosocial determinants of health, the WHO Regional Office for the Western Pacific embarked on the People at the Centre of Care Initiative. A policy framework was developed and presented at the fifty-eighth session of the Regional Committee in Jeju, Republic of Korea, in September 2007. The meeting endorsed the policy framework through resolution WPR/RC58.R4.

The Regional Committee is requested to note the update and the importance of implementing progressive national and regional actions towards achieving people-centred health care in the Region.

AVIAN AND PANDEMIC INFLUENZA AND THE ASIA PACIFIC STRATEGY FOR EMERGING DISEASES

1. BACKGROUND AND ISSUES

The Asia Pacific Strategy for Emerging Diseases is being implemented as a common framework and tool for countries to strengthen the capacities required for confronting emerging infectious diseases and to meet the core capacity requirements for surveillance and response under the International Health Regulations (2005).

Since July 2006, the Asia Pacific Technical Advisory Group (TAG) for Emerging Infectious Diseases has held annual meetings to provide technical advice on APSED implementation, including technical advice on managing avian and pandemic influenza. The Regional Committee, at its fifty-eighth session, adopted resolution WPR/RC58.R3 where it endorsed the recommendations of the second TAG meeting held in July 2007 and called for their effective implementation.

While considerable progress has been made to improve country-level readiness for avian and pandemic influenza, and other emerging infectious diseases, a number of issues remain. Avian influenza continues to occur and the pandemic risk persists. Meanwhile, epidemic-prone diseases such as cholera continue to pose serious public health threats. Countries will need to accelerate implementation of APSED to achieve the core capacity development goal by 2010.

2. ACTIONS TAKEN

A number of important actions have been taken to strengthen country and regional capacities for preventing, detecting, assessing, responding to and preparing for emerging diseases and/or public health events, using the APSED approach.

Countries affected by avian influenza have rapidly responded to the human infections of the H5N1 virus due to strengthened country capacities for surveillance and response. Through timely reporting of avian influenza cases and rapid exchange of information with WHO, countries have built public confidence concerning their response to avian influenza.

In collaboration with WHO and partner organizations, Member States continued to test and validate their pandemic preparedness plans through appropriate exercises. Following the initial PanStop exercise in April 2007, rapid containment exercises were conducted in the Lao People's Democratic Republic in November 2007 and in the Philippines in March 2008 to examine country-level operational capacity. The experiences and lessons learnt from the exercises will help develop national protocols for pandemic influenza rapid containment operations.

A meeting of Pacific National IHR Focal Points was held in October 2007 in Fiji to facilitate APSED implementation in the Pacific. Since then, seven Pacific island countries have conducted an assessment of their existing national capacities by using an IHR-APSED assessment tool developed by WHO. Five countries have developed their draft national plans of action to address capacity gaps.

Priority actions were taken to strengthen event-based surveillance, field epidemiology training, laboratory bio-safety, infection control, risk communication and zoonoses. A guide on establishing event-based surveillance was published in May 2008 and a pilot study is ongoing in several countries. Field epidemiology training was conducted in a number of Member States. Training of regional partners of the Global Outbreak Alert and Response Network (GOARN) was also carried out to strengthen regional response capacity. A regional bio-safety consortium was established to provide technical advice to Member States in strengthening laboratory bio-safety programmes. An informal consultation on infection control was held in Hong Kong (China) in January 2008 to identify core components of infection control activities. A number of regional and national training workshops on risk communication were conducted to improve outbreak communication skills among national officials. A guide on zoonotic disease control, which calls for collaboration between animal and human health sectors at the country level, was developed in 2008.

Influenza, including seasonal influenza, continued to be a priority disease in the Region. WHO has collaborated with Cambodia, China, Fiji, the Lao People's Democratic Republic, Mongolia and Papua New Guinea in developing and strengthening national influenza surveillance systems. WHO's guidelines for influenza surveillance and disease burden studies were developed in 2008.

3. ACTION PROPOSED

The Regional Committee for the Western Pacific is asked to note the progress in implementing the Asia Pacific Strategy for Emerging Disease.

VACCINE-PREVENTABLE DISEASES: POLIOMYELITIS, MEASLES AND HEPATITIS B

1. BACKGROUND AND ISSUES

The Regional Committee at its fifty-sixth session in September 2005 set twin regional goals of eliminating measles and reducing the prevalence of chronic hepatitis B virus infection to less than 2% in five-year-old children by 2012. Member States were urged to maintain poliomyelitis-free status by sustaining high-quality acute flaccid paralysis (AFP) surveillance and high immunization coverage with polio vaccine. Several countries and areas have interrupted endemic measles virus transmission and reduced hepatitis B chronic infection rates to less than 2% among five-year-old children. The Region has remained poliomyelitis-free since certification in 2000, despite the persistent risk of wild poliovirus importation from endemic areas. The basic strategies for achieving or maintaining disease eradication, elimination and control goals include high routine immunization coverage, periodic supplementary immunization activities (SIAs) when routine coverage is inadequate, and high-quality monitoring and surveillance.

Reported routine immunization coverage is high for the Region overall. In 2006, 92% of the Region's children were vaccinated with a first dose of measles containing vaccine (MCV1), and 19 of 32 countries submitting WHO-UNICEF Joint Reporting Forms reported MCV1 coverage greater than 90%. Similarly, 89% of children received three doses of hepatitis B vaccine (HepB3), with 26 of 32 countries reporting over 80% coverage. Three doses of polio vaccine were received by 92% of children, with 26 of 32 countries reporting at least 80% coverage. Nevertheless, several Member States, such as Cambodia, the Lao People's Democratic Republic and Papua New Guinea have been struggling to achieve or maintain the required levels of routine immunization coverage.

Large-scale, wide-age-range measles SIAs were conducted in Cambodia, China, the Lao People's Democratic Republic, Mongolia, the Philippines and Viet Nam in 2007. Oral poliovirus vaccine (OPV) was included in Cambodia. China, Papua New Guinea and Viet Nam have scheduled measles SIAs in 2008. Future periodic measles SIAs will be required in countries with inadequate routine MCV1 and MCV2 coverage. However, funding for measles SIAs beyond 2008 has not yet been identified. Targeted preventive SIAs with OPV may be required in countries where immunity levels are not high enough to prevent the spread of imported wild poliovirus or the occurrence of circulating vaccine-derived poliovirus. Case-based measles and AFP surveillance is required to monitor progress. However, shortages of human resources and financial constraints have hindered

many Member States from instituting adequate case-based laboratory surveillance for measles and for AFP surveillance.

For hepatitis B control, high routine immunization coverage is considered critically important, particularly with a timely HepB birth dose. China, accounting for 70% of all births in the Western Pacific Region, has made substantial progress in increasing the HepB birth dose coverage from less than 30% in 1997 to more than 80% in 2007, effectively reducing mother-to-child transmission of hepatitis B infection. Nevertheless, many other Member States are struggling to provide the first dose of HepB within 24 hours of birth to most newborn infants. Obstacles include a high proportion of home deliveries and coincidental adverse effects (e.g. neonatal death) following a HepB birth dose. Such coincidental occurrences set back the impressive gains made by Viet Nam in birth dose coverage between 2004 and 2006.

High-quality, case-based surveillance for measles and AFP is critical to quickly identify and respond to suspected cases of measles and poliomyelitis. Surveillance and coverage monitoring are essential to monitor progress towards the measles elimination goal. Standardized indicators have been developed and shared with all Member States. However, most Member States do not yet report, and may not even collect, the core data required to adequately monitor measles surveillance quality and reliably determine measles incidence. The level of quality of AFP surveillance has fallen below certification standards in some Member States, preventing timely detection of and response to poliomyelitis occurrence.

2. ACTIONS TAKEN

Member States are highly aware of the rationale for measles elimination and hepatitis B control and have included these goals in national multi-year plans for immunization. The WHO Regional Office for the Western Pacific helped priority Member States to update their comprehensive, fully costed plans for 2007–2008 to reflect activities and strategies needed to achieve the two regional goals. Technical support was also provided to countries with low timely HepB birth dose coverage (e.g. Philippines, Papua New Guinea and the Lao People’s Democratic Republic) to implement the guidelines for prevention of mother-to-child transmission. In addition, continuous assistance was provided to enhance emergency preparedness plans for potential importation of wild poliovirus.

The Regional Office coordinated funding and provided technical assistance to all countries conducting measles SIAs in 2008. Standard indicators for monitoring progress towards measles elimination, including indicators addressing incidence, surveillance performance, and population immunity, were developed and disseminated to countries through the Measles Bulletin. In July 2008, the Regional Office conducted a vaccine-preventable disease surveillance workshop focusing on case-based measles and AFP surveillance, as well as a measles and polio laboratory networks meeting. The Regional Office prepared a five-year strategic action plan to guide Member States to measles elimination by 2012. In addition, *Field Guidelines for Measles Elimination* have been updated and *Guidelines for the Introduction of Rubella Vaccine* have been developed.

Furthermore, the Regional Office developed certification guidelines for validation of achievement of the hepatitis B control goal, following an expert consultation. The regional plan for hepatitis B control was updated in 2007 to reflect the time-bound control goal and strategies needed to achieve it. The Republic of Korea became the first country in 2008 to be certified for achieving the regional hepatitis B control goal. Further consultations for the certification process have started in countries where recent data showed declines in HbsAg rates to less than 2% among children at least five years old.

The Regional Office, together with its polio partners, continued to provide technical support for activities required to maintain poliomyelitis eradication. Maintaining poliomyelitis-free status through preventive measures requires fewer resources than controlling poliomyelitis outbreaks following importation. The Regional Office has developed a multi-year strategic plan (2008–2012) to serve as an overall guide for activities to maintain regional poliomyelitis-free status.

3. ACTIONS PROPOSED

The following actions by Member States are proposed for consideration by the Regional Committee:

(1) Maintain commitments made at the fifty-sixth session of Regional Committee for the Western Pacific to strengthen, regularly update and implement national plans of action to meet the twin goals of measles elimination and hepatitis B control by 2012 and to maintain the poliomyelitis-free status.

(2) Mobilize sufficient internal and external financial, human and multisectoral resources for improving immunization services, co-financing essential SIAs, and improving case-based surveillance for measles and AFP that satisfies all WHO-recommended surveillance performance indicators.

(3) Adopt WHO-recommended indicators for monitoring progress towards measles elimination.

The Regional Committee is asked to note this report.

HIV/AIDS INCLUDING SEXUALLY TRANSMITTED INFECTIONS

1. BACKGROUND AND ISSUES

HIV spread in the Western Pacific Region is largely driven by high-risk behaviours such as unprotected commercial sex, sharing of contaminated needles and syringes among injecting drug users, and unprotected sex between men. New estimates indicate that 1.3 million people, including 21 000 children, were living with HIV/AIDS in the Region in 2007, compared to 750 000 in 2001. Some 150 000 new HIV infections occurred in 2007, together with 63 000 AIDS-related deaths. However, different trends have emerged in two of the most affected countries. In Cambodia, the HIV prevalence rate in adults declined from an estimated peak of 2% in 1998, to 0.9% in 2006; while in Papua New Guinea, which still faces a generalized epidemic, the HIV prevalence rate rose to 1.3% in 2006. As an additional public health concern, high rates of sexually transmitted infections (STI) continue to be recorded. A recent survey in Papua New Guinea indicated that about 40% of the adult population were suffering from at least one STI. In Mongolia, the number of reported cases of congenital syphilis increased almost six fold from 1997 to 2006. Similarly, the incidence of syphilis in China rose from less than 0.2 cases per 100 000 people in 1993 to 13.3 per 100 000 in 2006. TB-HIV co-infection remains a serious problem in several provinces of Cambodia, Papua New Guinea and Viet Nam, and is a growing concern in some population groups in China and Malaysia.

Sustained political commitment and generous allocation of resources are supporting the scale-up of national responses. More people are being reached with HIV services and WHO continues to provide technical assistance as per the request of Member States. In Papua New Guinea, testing and counselling increased nearly nine fold, from 3052 clients tested and counselled in 2006 to more than

27 000 in 2007. In Cambodia, there has been a five-fold increase in the number of HIV testing and counselling sites, from 36 sites in 2002 to 190 sites as of the end of 2007. Countries have expanded needle-syringe programmes and have added methadone centres and 100% condom use programme sites, thereby contributing to the reduction of HIV transmission through sharing of needles and syringes and unprotected commercial sex. In the Region, 28% of people living with HIV and in need of treatment were receiving antiretroviral therapy (ART) as of the end of 2007. Nearly five times as many people were receiving ART in 2007 as compared to 2004. In Cambodia, the number of people receiving ART has more than doubled in the last two years.

Despite this progress, much remains to be done. A large proportion of people living with HIV remain unaware of their HIV status. Coverage of interventions for the prevention of HIV transmission is still limited, particularly for marginalized populations such as sex workers, injecting drug users, and men who have sex with men including transgender individuals. Despite the substantial progress in access to treatment, many vulnerable populations such as injecting drug users are still significantly underserved. More accurate strategic information is needed to ensure guidance for proper planning of interventions and allocation of resources. There is increasing concern of the growth of the dual TB-HIV epidemic. Further, expansion of country responses depends on strong health systems and skilled human resources to deliver services. The links between HIV/STI programmes and other public health programmes need to be strengthened.

2. ACTIONS TAKEN

WHO has strengthened its human resources at regional and country levels to ensure the timely provision of technical support to countries. In 2007, the following norms and guidelines were developed across the five strategic directions of the WHO programme on HIV/AIDS:

(1) *Asia-Pacific Operational Framework for Linking HIV/STI Services with Reproductive, Adolescent, Maternal, Newborn and Child Health Services*;

(2) *Scaling Up HIV Testing and Counselling in Asia and the Pacific - Report of a Technical Consultation*;

(3) *Regional Strategic Action Plan for the Prevention and Control of Sexually Transmitted Infections, 2008–2012;*

(4) *A Revised Framework to Address TB-HIV Co-infection in the Western Pacific Region;*

(5) *HIV/AIDS Care and Treatment for People Who Inject Drugs in Asia and the Pacific - An Essential Practice Guide*;

(6) *Guidance on HIV Testing and Counselling in Injecting Drug Use Settings;*

(7) *The WHO Framework for Global Monitoring and Reporting on the Health Sector's Response towards Universal Access to HIV/AIDS Treatment, Prevention, Care and Support, 2007-2010.*

Technical support provided to Member States has included: (1) scaling up HIV testing and counselling; (2) strengthening prevention and control of STI through improvement of STI case management, expansion of access to STI care, elimination of congenital syphilis, reduction of STI transmission and improvement of data management; (3) scaling up evidence-based strategies for both HIV prevention, care, treatment and support with most-at-risk populations; (4) strengthening HIV surveillance systems including second generation surveys, antiretroviral (ARV) drug resistance and gonococcal antimicrobial susceptibility surveillance; and (5) building stronger health systems through investing in building human resource capacity, training on procurement and supply management, and in STI and HIV laboratory diagnostic procedures and lot quality management systems.

WHO assisted China in developing national guidelines for responding to the needs of men who have sex with men. It also provided technical support to countries for reallocating internal resources and developing sustainable financing mechanisms for HIV/AIDS prevention, care and treatment, particularly through funding proposals to Round 7 of the Global Fund to Fight AIDS, Tuberculosis and Malaria. HIV proposals submitted by Cambodia, Mongolia and countries in the Pacific were successful. Technical assistance was also provided to countries for developing submissions for Round 8 of the Global Fund.

3. ACTIONS PROPOSED

The following actions by Member States are proposed for consideration by the Regional Committee:

(1) Sustain political commitment through the participation of government leaders in national HIV governing and/or coordinating bodies; allocation of national budget for HIV/AIDS

programmes; conduct of biennial HIV impact assessment and analysis to review latest epidemiological evidence and current HIV response to support proper planning of interventions.

(2) Revisit existing national strategic plans and intervention packages on HIV/AIDS and sexually transmitted infections to strengthen efforts towards scaling up HIV counselling and testing; increasing coverage of prevention of HIV transmission; providing care, treatment and support to those in need; generating high-quality strategic information; and building stronger health systems.

(3) In line with human rights and public health principles, refrain from introducing cohesive measures for mandatory HIV testing and support access and availability of quality counselling services. Create an enabling environment for HIV interventions, for example, through review of national legislation that is inconsistent with national AIDS control policies and enact or revise legislation as part of an effort to destigmatize HIV-associated risk behaviour and prevent and fight discrimination especially in the workplace and health care settings.

(4) Accelerate the scale-up of HIV/AIDS prevention, care and treatment programmes by prioritizing interventions that can have the most sustainable effect on reducing the HIV transmission and the impact of the epidemic, for example, comprehensive harm-reduction programmes for marginalized populations.

(5) Strengthen surveillance and monitor implementation of national HIV/AIDS and sexually transmitted infections plans to ensure that populations at increased risk of HIV and sexually transmitted infections have access to prevention, information and commodities (condoms, needles, etc.) and to timely diagnosis and treatment.

(6) Advocate at the country level with the two programmes—national AIDS programme and national TB programme—to strengthen the link between HIV and tuberculosis diagnosis and treatment and to boost service delivery under both programmes.

PREVENTION AND CONTROL OF TUBERCULOSIS

1. BACKGROUND AND ISSUES

Tuberculosis (TB) is a major public health problem in the Western Pacific Region. The latest epidemiological data show an estimated 3.5 million prevalent TB cases, of which 1.9 million were new cases, with more than 290 000 people dying from TB in 2006. Multidrug-resistant TB (MDR-TB) has become a serious concern, with more than one quarter of the global burden estimated to be in the Region. The estimated prevalence of HIV in reported TB cases remains low at 1.2%, but a significant threat in several areas.

The Region is gaining momentum in achieving the regional goal set by the WHO Regional Committee for the Western Pacific in 2000 of reducing by one half the TB prevalence and mortality in the decade ending 2010. The Region's case detection rate and treatment success rates, 77% and 88% respectively, continue to exceed global targets. Estimates of TB prevalence and mortality show a decline of 24% and 15%, respectively, between 2000 and 2006, yet the annual rates of decline of 4.9% and 3.8% are not sufficient to achieve the regional goal by 2010. The following are constraining efforts to achieve a much faster decline in the TB burden.

1.1 Insufficient progress in scaling up programmatic management of MDR-TB and TB-HIV collaborative activities

The scale-up of programmatic management of MDR-TB has been slow in countries most affected by MDR-TB in the Region. By 2007, the number of MDR-TB cases enrolled for treatment in the Region, overall, was only 2000, which is well below the target of 10 000 cases set by the Global MDR-TB and XDR-TB Response Plan. Expanding coverage of quality-assured MDR-TB treatment is constrained by many factors including, insufficient laboratory capacity, limited human resource capacity, policy constraints and procurement issues. Similarly, progress is slow in expanding TB-HIV collaborative activities, particularly in testing TB patients for HIV and implementing isoniazid preventive therapy. Despite significant progress in Cambodia, Malaysia and Viet Nam, the Region, overall, is testing less than 2.5% of TB patients for HIV, well below the target of 50% by 2010. Less than 1% of the people with HIV/AIDS are provided with isoniazid prophylaxis.

1.2 Limited progress in scaling up access to newer and more sensitive tests for TB

Early detection of TB cases is a crucial component to the strategy of reducing the TB burden, in particular for addressing MDR-TB and TB-HIV co-infection by interrupting transmission and preventing mortality due to TB among people with HIV/AIDS. The laboratories play a critical role, yet capacity in countries remains insufficient to detect drug-resistant TB and TB among people with HIV. The insufficient capacity for quality-assured culture and drug susceptibility testing in most countries is leading to a low proportion of TB cases tested for MDR-TB. Only 1% of re-treatment cases, which are more likely to acquire drug-resistant TB, undergo quality-assured testing for MDR-TB. Moreover, there is a need for countries to prepare for the eventual scale up new tests, i.e., molecular line probe assay, which will help in the early detection and treatment of people with drug-resistant TB. At the same time, strengthening quality assurance of the laboratory network and promoting bio-safety in laboratories will be essential.

1.3 Infection control in health facilities not adequately addressed

The lack of well-established infection control measures in most health facilities and in congregate settings is a serious concern, particularly in the context of MDR-TB, extensively drug resistant-TB (XDR-TB) and the TB-HIV co-infection. Preventing transmission among health workers and people in congregate settings is crucial, not only for its implication on TB prevalence and mortality but also in alleviating stigma, as had been the experience in Africa. In the Western Pacific Region, infection control has been a neglected area, which is related to the lack of awareness of its importance, limited technical capacity and health systems limitations. Poor infection control in health care settings increases the risk of the spread of tuberculosis, particularly for people at higher risk of acquiring TB, i.e. people with HIV/AIDS and TB staff involved in the diagnosis and management of MDR-TB.

1.4 Declining funding for technical assistance

Implementing the regional Strategic Plan to Stop TB in the Western Pacific (2006–2010), endorsed by the Regional Committee in 2006, particularly for addressing the challenges posed by MDR-TB, XDR-TB and TB-HIV co-infection, requires complex and technically demanding activities. This increasing complexity and expanding funding for TB control activities in countries are posing increasing demands for technical assistance. WHO is the main provider of technical assistance in these areas; however, WHO's capacity to deliver adequate technical assistance is threatened by

declining funding–almost a 50% decline in 2008 from 2003 level. The continuity of country-based technical assistance is threatened by the lack of predictability of funding from 2009 onwards.

2. ACTIONS TAKEN

2.1 Addressing MDR-TB and TB-HIV co-infection

Programmatic management of MDR-TB is being expanded in Mongolia and the Philippines, and initiated in Cambodia, China and Viet Nam. In all these countries, MDR-TB management plans have been developed and approved by the Green Light Committee and more than US$ 100 million to finance country activities against MDR-TB has been mobilized from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Region is also continuing to build technical capacity through the regional advance TB course conducted every year. In the Pacific, WHO, in collaboration with partners has established a mechanism for providing access to quality-assured testing and treatment of MDR-TB in the countries and areas.

At the regional level, an important milestone on TB-HIV collaboration has been achieved through the revision of the TB-HIV framework. The framework aims to strengthen collaboration between national TB and AIDS programmes, increase the rates of HIV testing among TB patients and of TB screening among people with HIV, and improve infection control.

2.2 Strengthening capacity and quality of laboratory networks

Intensified advocacy efforts are leading to greater attention being given to laboratories, particularly in the implementation of laboratory quality assurance regionwide, including in the Pacific. These advocacy efforts are also beginning to bring awareness to the need to upgrade the capacity of laboratories so they can adopt newer and more sensitive tools for TB diagnosis. The Region is supporting several countries in planning to advance towards universal access to culture and drug susceptibility testing, and for the eventual roll-out of molecular tests for MDR-TB. This will be the main focus in the next national laboratory workshop in October 2008. Laboratories, along with MDR-TB and TB-HIV, featured prominently during the discussion in the Technical Advisory Group Meeting and Japan TB Symposium held in Tokyo, Japan, in July 2008.

2.3 Strengthening infection control in health facilities

The strategy to address infection control is seen to cut across several disease control efforts within the context of health systems strengthening. WHO is fostering collaboration within disease control programmes at regional and country levels so that careful assessments can be made of the implementation of infection control measures in health facilities, and to identify and recommend measures to address gaps. Countries and areas in the Region face enormous challenges, including lack of technical capacity. A series of country-level assessments and capacity-building workshops are being planned for next year.

2.4 Mobilizing resources for TB control

Substantial progress has been achieved in mobilizing financing for TB control activities at the country level, particularly from the Global Fund, with strong support from WHO. The Region has generated US$ 370 million for TB control from the Global Fund. On the contrary, mobilizing funding for technical assistance is an increasing challenge. Stop TB is applying a two-pronged approach for increasing funding for technical assistance: (1) mobilize donor support; and (2) generate technical assistance funding from the Global Fund. WHO has been building momentum in these areas by organizing the Partners Roundtable Discussion in March 2008 in Brisbane, Australia, and the Interagency Coordinating Committee in July 2008 in Tokyo, Japan.

3. ACTIONS PROPOSED

The following actions by Member States are proposed for consideration by the Regional Committee:

(1) Accelerate the scale-up of programmatic management of TB in countries affected by multidrug-resistant TB to detect and treat at least 50% of the estimated MDR-TB cases.

(2) Develop and implement a laboratory scale-up plan to achieve universal access to quality-assured culture and drug susceptibility testing. Countries should prepare for the eventual roll-out of a molecular test for MDR-TB. At least, all re-treatment cases should be tested for MDR-TB.

(3) Endorse the revised Framework to Address the TB-HIV Co-infection in the Western Pacific Region, and develop and implement joint national plans to accelerate the implementation of TB-HIV collaborative activities based on the Framework.

(4) Develop and implement comprehensive infection control strategies in all health care settings. Policies and measures should be in place to protect people at higher risk for acquiring TB in health care facilities.

(5) Help ensure that adequate technical assistance is provided to further strengthen TB control programmes.

TOBACCO CONTROL

1. BACKGROUND AND ISSUES

Tobacco use is the second major cause of death in the world. In the 20th century, the tobacco epidemic killed 100 million people worldwide. Unless urgent action is taken it could kill one billion people during the 21st century. Eighty per cent of these deaths will occur in developing countries. One third of the world's smokers reside in the Western Pacific Region where it is estimated that two people die every minute from a tobacco-related disease. Compared with other WHO regions, the Western Pacific has the greatest number of smokers, among the highest rates of male smoking prevalence, and the fastest increase of tobacco use uptake by women and young people. Recent research shows that up to 50% of all young people in the Region are regularly exposed to tobacco smoke pollution in their homes.

The WHO Framework Convention on Tobacco Control (FCTC), which came into force in 2005, drives the global tobacco control agenda. It has been ratified by 152 countries. The WHO Western Pacific Region was the first and is still the only region that has achieved 100% ratification of the WHO FCTC, with all 27 eligible Western Pacific Member States bound by its provisions.

The Regional Committee for the Western Pacific, at its fifty-eighth session, encouraged Member States to maintain the commitments made at the fifty-fifth session, including implementing tobacco control measures beyond those required by the Convention and its protocols, and using the

Convention and the Tobacco Free Initiative Regional Action Plan (2005–2009) to guide national tobacco control policies and programmes.

2. ACTIONS TAKEN

The first session of the Intergovernmental Negotiating Body on a Protocol on Illicit Trade in Tobacco Products was convened in February 2008 in Geneva. From the Western Pacific Region, 24 of the 27 parties to the WHO FCTC attended the session. Overall, delegations voiced their support for a protocol on illicit trade in tobacco products with clear and strong obligations. A number of delegations gave examples of measures taken by their governments to suppress the illicit trade of tobacco products but recognized that a coordinated global approach was necessary for a comprehensive solution.

The WHO Report on the Global Tobacco Epidemic, 2008 was launched in February 2008. This landmark report provides comprehensive information on the status of effective tobacco control measures in almost every country and identifies gaps in information, data and policies that must be filled. Moreover, the report outlines the MPOWER package, a set of six proven cost-effective tobacco control measures: (1) monitor tobacco use and prevention policies; (2) protect people from tobacco smoke; (3) offer help to quit tobacco use; (4) warn about the dangers of tobacco; (5) enforce bans on tobacco advertising, promotion and sponsorship; and (6) raise taxes on tobacco.

A few Western Pacific Member States have already met Convention requirements, several more are making good progress in implementing Convention provisions, and some are seeing decreases in smoking prevalence through the enforcement of evidence-based tobacco control measures. The Mongolia National Council on Standardization approved six pictorial health warnings to be effective in January 2010 in compliance with Convention provisions. The Mongolia Health Promotion Foundation is funded through an excise tobacco tax of 2% that is now used for health promotion activities. As of January 2008, Viet Nam has raised tobacco excise taxes to 65% of the factory price from 55% in 2006. From 1 April 2008, Viet Nam has been printing tobacco packs with new health warnings that account for 30% of the main displayed surfaces. The Viet Nam National Assembly has entered the draft tobacco control law in the law-making agenda for 2009-2010. In April 2008, the Parliament of Vanuatu passed comprehensive legislation for tobacco control. With the support of WHO and the Johns Hopkins Bloomberg School of Public Health, the Chinese Ministry of Finance held a workshop on tobacco economics and taxation to demonstrate the Government's

commitment to strengthening tax measures for tobacco control in the near future. In line with efforts to make the Beijing 2008 Olympic Games smoke free, the Beijing municipal government introduced a regulation that bans smoking in public places from 1 May 2008. Similarly, the Philippines has begun enforcing a law that bans tobacco advertising in media and on billboards.

With support from the Japanese Government and the United States Centers for Disease Control and Prevention, WHO has continued to provide targeted, country-level technical assistance, capacity-building and other support to Member States for implementation of the Framework Convention on Tobacco Control. In addition to country-level assistance, WHO conducted a regional workshop on sustaining action for the WHO FCTC and a training session on tobacco control policies and programmes in August 2008. These activities addressed the challenges related to institutionalization of tobacco control programmes, funding for tobacco control activities and more effective use of evidence for policy. In particular, the workshop prepared the Region's parties for active participation in the third session of the Conference of the Parties that is scheduled for November 2008. A template for tobacco control training of local stakeholders has also been developed for adaptation in countries.

WHO supported country-level advocacy efforts that promote the ban on tobacco advertising, promotion and sponsorships that target youth—in line with the 2008 World No Tobacco Day theme, "Tobacco-Free Youth". The regional launch of the World No Tobacco Day was hosted by the Department of Health of the Philippines and included a press conference with Yuhta Ohishi, a 15-year-old boy from Shiyoda, Japan, who received the Director-General's Special Recognition Certificate for successfully campaigning for local tobacco control regulations in his city. WHO actively supported the work of stakeholders in ensuring smoke-free policies and enforcement in venues of the 2008 Beijing Olympics.

WHO, together with four partners, continued to carry out the Bloomberg Global Initiative to Reduce Tobacco Use, a two-year US$ 125 million initiative funded by the Bloomberg Philantrophies. The initiative provides grants for projects in 15 developing countries, including China, the Philippines and Viet Nam. The projects supported by these grants have led to substantial, sustainable improvements in tobacco control laws, regulations, policies and programmes.

Research on betel nut and tobacco use in the Pacific has been published and disseminated as an effort to expand the regional evidence base for tobacco control. As part of the global tobacco surveillance system, 25 countries and areas have completed or are in the process of completing the Global Youth Tobacco Survey, the Global School Personnel Survey, and the Global Health Professional Student Survey. WHO is also spearheading the development of the new Global Adult

Tobacco Survey in partnership with the Centers for Disease Control Foundation. The Global Adult Tobacco Survey is a standardized, comparable adult household survey on tobacco use knowledge, attitudes and behaviours. Implementation has started in the Philippines and Viet Nam and preparatory work for implementation in China has commenced.

WHO promoted integration of tobacco control efforts with other public health strategies. At the 4th Japan-WHO International Visitors Programme on NCD Prevention and Control, held at the National Institute for Public Health in Japan, participants from China, Fiji, the Lao People's Democratic Republic, Mongolia, the Philippines and Viet Nam cited the MPOWER package as critical to the regional strategy for noncommunicable disease prevention and control. Through the health promotion leadership training programme (ProLead), participants from Brunei Darrusalam, Cambodia, Fiji, Kiribati, the Lao People's Democratic Republic, Papua New Guinea, Samoa, Solomon Islands, Vanuatu and Viet Nam learnt the importance of taxing tobacco products and using the funds for tobacco control and health promotion.

3. ACTIONS PROPOSED

WHO will continue to put the highest priority on providing technical assistance and capacity-building to address the politics of tobacco control by aggressively promoting evidence-based policies within the framework of MPOWER. Support for effective implementation of the Convention by parties in the Region will be sustained. WHO will actively engage all Member States in addressing challenges related to sustained action and advocacy for tobacco control. It will also encourage institutionalization of tobacco control programmes, integration of tobacco control in national noncommunicable disease control plans of action and use of tobacco taxes for the promotion of health. WHO will accelerate efforts to disseminate good practices from activities under the Bloomberg Initiative and will continue to mobilize resources for tobacco control. Surveillance and research will be sustained.

The following actions are proposed for consideration by Member States

(1) Make efforts to meet the provisions of the Convention beyond its minimum requirements and in fully implementing the Guidelines for the implementation of Article 8 (Protection from exposure to tobacco smoke), which was adopted by the second Conference of the Parties in 2007. Member States need to put in place administrative, legal and sustainable financial

measures to sustain and scale up tobacco control efforts, being mindful of political factors that serve as barriers to effective policies. Member States are also asked to contribute to the upcoming second session of the Intergovernmental Negotiating Body on illicit trade to develop a strong protocol this October and the third session of the Conference of the Parties this November to further enhance the implementation of the WHO Framework Convention on Tobacco Control.

(2) Put tobacco control higher in the agenda of national health priorities and implement the Tobacco Free Regional Action Plan 2005–2009. Priority should be given to six evidence-based policies as identified in the *WHO Report on the Global Tobacco Epidemic, 2008* , i.e. the MPOWER package.

The Regional Committee is asked to note this report.

PEOPLE AT THE CENTRE OF CARE INITIATIVE

1. BACKGROUND

Economic, demographic and social forces have increasingly put pressure on health systems not only to provide universally accessible, effective and scientifically sound health care, but also to ensure that services are designed and delivered in ways that respect patients' rights and suit their needs and preferences for information, psychosocial support and participation in decision-making for their own care. Thus, the need for innovative, balanced, holistic and people-centred approaches to health care has become a matter of concern for countries and health systems worldwide.

The WHO Regional Committee for the Western Pacific has adopted various resolutions addressing broader issues and determinants of health as they significantly impact health care, health outcomes, satisfaction with care, and overall population health and well-being. Resolution WPR/RC55.R1 specifically requested the WHO Regional Office for the Western Pacific to produce a draft policy framework reflecting the significance of psychosocial factors affecting health outcomes. WHO embarked on the People at the Centre of Care Initiative, with strong support from the Government of Japan.

The initiative developed a policy framework through a process involving a reference group of experts as well as stakeholder consultations in selected countries. The policy framework was presented at the fifty-eighth session of the Regional Committee, which endorsed the framework through resolution WPR/RC58.R4. Intended to serve as a guide for Member States to develop and implement people-centred health care policies and interventions according to their national contexts, it called for policy changes and interventions in four action domains: (1) individuals, families and communities; (2) health practitioners; (3) health care organizations; and (4) health systems.

2. ACTIONS TAKEN

The Regional Office led the development of the biregional publication *People at the Centre of Health Care: Harmonizing Mind and Body, People and Systems*, an elucidation in popular language of the principles and proposed actions embodied in the document *People-Centred Health Care: A Policy Framework*. The advocacy book was launched at the International Symposium on People-Centred Health Care: Re-orienting Health Systems in the 21st Century, held in Tokyo, Japan on 25 November 2007. The symposium reaffirmed the principles and areas of action contained in the WHO publications on people-centred health care and made recommendations on taking the work forward. The publications and the proceedings of the symposium are available online (www.wpro.who.int/sites/pci/publications.htm).

In accordance with the provisions of resolution WPR/RC58.R4, advocacy and dissemination of the concept and principles of people-centred care were undertaken through presentations and discussions with various groups in important international and regional forums: (1) Third Global Patients Congress held in February 2008 in Budapest, (2) First International Conference on Health Care Transformation: Primary Care Focus held in May 2008 in Singapore, and (3) 49th Annual Congress of the Japan Neurogical Society held in Japan. Further, to reach a wider audience, the policy framework and advocacy book will be translated into Mandarin and Japanese.

In collaboration with the Southeast Asian Ministers of Education Organization-Tropical Medicine and Public Health Network (SEAMEO-TROPMED), the Regional Office convened a forum in July 2008 for heads of schools and training institutions that teach medical and allied health professionals. The forum resulted in specific recommendations and indications of commitment to strategic measures that institutions can take, e.g. enriching the curriculum to promote people-centred health care. WHO also is formulating indicators, standards, guidelines and tools for monitoring and

assessing progress towards people-centred health care. Relevant experts will be consulted in an effort to provide normative and practical guidance to Member States in the reorientation of health systems towards people-centred health care.

Resolution WPR/RC58.R4 specifically mandated WHO to support and work with Member States in developing action plans and implementation tools, including monitoring and evaluation mechanisms, to ensure that health policies and interventions lead to more people-centred health care, better health outcomes, and improved health and well-being. In this regard, WHO has secured financial support from the Government of Japan for the following activities:

(1) Workshop on the development of national plans and interventions towards people-centred health care. This activity will build on the work and recommendations of the consultations with heads of schools and training institutions for medical and other health professionals, and with experts in monitoring and evaluation.

(2) Implementation planning workshops at country level. The workshops will be conducted in countries that demonstrate political commitment and readiness.

(3) Baseline studies. The studies will be undertaken in countries where workshops will be held. A minimum core of indicators will be covered to provide relevant information prior to implementation of interventions.

3. ACTIONS PROPOSED

The Regional Committee is requested to note the update and the importance of implementing progressive national and regional actions towards achieving people-centred health care in the Region.

To facilitate work at country level, the following actions are proposed for consideration by Member States:

(1) Designate staff and/or units to lead and coordinate national actions to promote people-centred health care.

(2) Incorporate key principles and elements of the people-centred approach to health care in health policies, plans and programmes.